

2696

CERTIFICATE OF DEATH

02685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ocean City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berlin Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NORA BENSON		4. DATE OF DEATH Feb. 17, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Savage		14. MOTHER'S MAIDEN NAME Margaret (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) xx (If yes, give war or dates of service) xx		16. SOCIAL SECURITY NO. xx	
17. INFORMANT Ranzie Benson		Address Bishop, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart attack 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Ch. Myocarditis & Nephritis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 2 - 1960 , to Feb 17 - 1960 , that I last saw the deceased alive on Feb 17 - 1960 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Char. R. Law M.D. Berlin Md		ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED Feb 18 - 1960	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/20/60	22c. NAME OF CEMETERY OR CREMATORY Zion Church Yard	22d. LOCATION (City, town, or county) (State) Bishopville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley ADDRESS Berlin Md		24a. REC'D BY REGISTRAR FEB 23 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2700

CERTIFICATE OF DEATH

02686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 909 Clarke Avenue				d. STREET ADDRESS 909 Clarke Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joe Middle - Last Matthews				4. DATE OF DEATH Month February Day 9 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1863	
9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months 9 Days 9 Hours 9 Min.		IF UNDER 24 HRS. Months 9 Days 9 Hours 9 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Oyster		11. BIRTHPLACE (State or foreign country) Accomack County, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME (Unknown)				14. MOTHER'S MAIDEN NAME (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. N one		17. INFORMANT Son, Charles J. Matthews, Pocomoke City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Degenerative Heart Disease DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 1 day Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Extreme old age. atrophic changes.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Feb. 6, 1960 , to Feb. 9, 1960 , that I last saw the deceased alive on Feb. 9, 1960 , and that death occurred at 10:00 a.m. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED Feb. 9, 1960							
ACTUAL SIGNATURE Charles W. Trader M.D.							
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D., 302 Market Street, Pocomoke City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/60		22c. NAME OF CEMETERY OR CREMATORY John W. Taylor Memorial		22d. LOCATION (City, town, or county) (State) Temperanceville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Richard Johnson				ADDRESS Parkley, Va.		24a. REC'D BY REGISTRAR DATE FEB 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED JOHN J. HARRIS		2. SEX Male		3. AGE 65 years		4. RACE White	
5. PLACE OF BIRTH Baltimore, Md.		6. DATE OF BIRTH Jan. 15, 1885		7. PLACE OF DEATH Baltimore, Md.		8. DATE OF DEATH Jan. 15, 1950	
9. OCCUPATION Retired		10. MARITAL STATUS Married		11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF NEXT OF KIN John J. Harris, Jr.		15. SIGNATURE OF PHYSICIAN J. H. Harris		16. SIGNATURE OF REGISTRAR J. H. Harris	
17. ADDRESS OF DECEASED 1234 Main St., Baltimore, Md.		18. ADDRESS OF NEXT OF KIN 1234 Main St., Baltimore, Md.		19. ADDRESS OF PHYSICIAN 1234 Main St., Baltimore, Md.		20. ADDRESS OF REGISTRAR 1234 Main St., Baltimore, Md.	
21. DATE OF INTERMENT Jan. 15, 1950		22. PLACE OF INTERMENT St. Mary's Cemetery		23. NAME OF INTERMENT SOCIETY St. Mary's		24. NAME OF MINISTER Rev. J. H. Harris	
25. NAME OF FUNERAL HOME J. H. Harris		26. NAME OF CEMETERY St. Mary's		27. NAME OF MINISTER Rev. J. H. Harris		28. NAME OF DECEASED'S RELIGION Roman Catholic	
29. NAME OF DECEASED'S RELIGION Roman Catholic		30. NAME OF DECEASED'S RELIGION Roman Catholic		31. NAME OF DECEASED'S RELIGION Roman Catholic		32. NAME OF DECEASED'S RELIGION Roman Catholic	
33. NAME OF DECEASED'S RELIGION Roman Catholic		34. NAME OF DECEASED'S RELIGION Roman Catholic		35. NAME OF DECEASED'S RELIGION Roman Catholic		36. NAME OF DECEASED'S RELIGION Roman Catholic	
37. NAME OF DECEASED'S RELIGION Roman Catholic		38. NAME OF DECEASED'S RELIGION Roman Catholic		39. NAME OF DECEASED'S RELIGION Roman Catholic		40. NAME OF DECEASED'S RELIGION Roman Catholic	
41. NAME OF DECEASED'S RELIGION Roman Catholic		42. NAME OF DECEASED'S RELIGION Roman Catholic		43. NAME OF DECEASED'S RELIGION Roman Catholic		44. NAME OF DECEASED'S RELIGION Roman Catholic	
45. NAME OF DECEASED'S RELIGION Roman Catholic		46. NAME OF DECEASED'S RELIGION Roman Catholic		47. NAME OF DECEASED'S RELIGION Roman Catholic		48. NAME OF DECEASED'S RELIGION Roman Catholic	
49. NAME OF DECEASED'S RELIGION Roman Catholic		50. NAME OF DECEASED'S RELIGION Roman Catholic		51. NAME OF DECEASED'S RELIGION Roman Catholic		52. NAME OF DECEASED'S RELIGION Roman Catholic	
53. NAME OF DECEASED'S RELIGION Roman Catholic		54. NAME OF DECEASED'S RELIGION Roman Catholic		55. NAME OF DECEASED'S RELIGION Roman Catholic		56. NAME OF DECEASED'S RELIGION Roman Catholic	
57. NAME OF DECEASED'S RELIGION Roman Catholic		58. NAME OF DECEASED'S RELIGION Roman Catholic		59. NAME OF DECEASED'S RELIGION Roman Catholic		60. NAME OF DECEASED'S RELIGION Roman Catholic	
61. NAME OF DECEASED'S RELIGION Roman Catholic		62. NAME OF DECEASED'S RELIGION Roman Catholic		63. NAME OF DECEASED'S RELIGION Roman Catholic		64. NAME OF DECEASED'S RELIGION Roman Catholic	
65. NAME OF DECEASED'S RELIGION Roman Catholic		66. NAME OF DECEASED'S RELIGION Roman Catholic		67. NAME OF DECEASED'S RELIGION Roman Catholic		68. NAME OF DECEASED'S RELIGION Roman Catholic	
69. NAME OF DECEASED'S RELIGION Roman Catholic		70. NAME OF DECEASED'S RELIGION Roman Catholic		71. NAME OF DECEASED'S RELIGION Roman Catholic		72. NAME OF DECEASED'S RELIGION Roman Catholic	
73. NAME OF DECEASED'S RELIGION Roman Catholic		74. NAME OF DECEASED'S RELIGION Roman Catholic		75. NAME OF DECEASED'S RELIGION Roman Catholic		76. NAME OF DECEASED'S RELIGION Roman Catholic	
77. NAME OF DECEASED'S RELIGION Roman Catholic		78. NAME OF DECEASED'S RELIGION Roman Catholic		79. NAME OF DECEASED'S RELIGION Roman Catholic		80. NAME OF DECEASED'S RELIGION Roman Catholic	
81. NAME OF DECEASED'S RELIGION Roman Catholic		82. NAME OF DECEASED'S RELIGION Roman Catholic		83. NAME OF DECEASED'S RELIGION Roman Catholic		84. NAME OF DECEASED'S RELIGION Roman Catholic	
85. NAME OF DECEASED'S RELIGION Roman Catholic		86. NAME OF DECEASED'S RELIGION Roman Catholic		87. NAME OF DECEASED'S RELIGION Roman Catholic		88. NAME OF DECEASED'S RELIGION Roman Catholic	
89. NAME OF DECEASED'S RELIGION Roman Catholic		90. NAME OF DECEASED'S RELIGION Roman Catholic		91. NAME OF DECEASED'S RELIGION Roman Catholic		92. NAME OF DECEASED'S RELIGION Roman Catholic	
93. NAME OF DECEASED'S RELIGION Roman Catholic		94. NAME OF DECEASED'S RELIGION Roman Catholic		95. NAME OF DECEASED'S RELIGION Roman Catholic		96. NAME OF DECEASED'S RELIGION Roman Catholic	
97. NAME OF DECEASED'S RELIGION Roman Catholic		98. NAME OF DECEASED'S RELIGION Roman Catholic		99. NAME OF DECEASED'S RELIGION Roman Catholic		100. NAME OF DECEASED'S RELIGION Roman Catholic	

2705

CERTIFICATE OF DEATH

02687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHOWGILLS</u>		c. LENGTH OF STAY IN 1b <u>89 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X SHOWGILLS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>THOMAS</u> Last <u>MUMFORD</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>22</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 20, 1890</u>		9. AGE (In years lost birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD (RFD)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS MUMFORD</u>				14. MOTHER'S MAIDEN NAME <u>ANNE MARIAH CLARK.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-5102</u>		INFORMANT Address <u>MR CHARLES MUMFORD SHOWGILL MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis (acute)</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atypical pneumonia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 14</u> , <u>1962</u> , to <u>Feb. 22</u> , <u>1960</u> , that I last saw the deceased alive on <u>Feb. 21</u> , <u>1960</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank R. Lewis</u>				ADDRESS (Street, city or town, state) <u>Willards, Maryland</u>		DATE SIGNED <u>2/23/60</u>	
PHYSICIAN'S NAME (Type) <u>Frank R. Lewis M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LEWIS</u>		22d. LOCATION (City, town, or county) (State) <u>WHALEVILLE (RFD) MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Bubage Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2701

CERTIFICATE OF DEATH

Reg. Dist. No.

02688

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 121 Sixth Street				d. STREET ADDRESS 121 Sixth Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ASHER Middle GREENSBORO Last PARSONS				4. DATE OF DEATH Month February Day 11 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1892		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sidney Parsons				14. MOTHER'S MAIDEN NAME Leona Figgs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-4744		17. INFORMANT Address Mrs Ruth V. Parsons, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA RIGHT LUNG DUE TO (c) 2 YEARS						INTERVAL BETWEEN ONSET AND DEATH 3 MONS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from FEB 18 , 19 56 , to FEB 11 , 19 60 , that I last saw the deceased alive on FEB 11 , 19 60 , and that death occurred at 5:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Stanford Hamilton M.D.				ADDRESS (Street, city or town, state) 22 MARKET ST. DATE SIGNED 2/12/60			
PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON, M.D. POCOMOKE CITY, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-60		22c. NAME OF CEMETERY First Baptist		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Watson ADDRESS Pocomoke City, Md				24a. REC'D BY REGISTRAR DATE FEB 15 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JOHN J. DEAN		MALE		35		JANUARY 22, 1905		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
101 E. 1st Street		LABORER		HEART DISEASE		SUICIDE		BALTIMORE, MARYLAND	
DATE OF DEATH		HOUR OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
JANUARY 22, 1940		10:30 AM		10:30 AM		98.6		60	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
J. J. DEAN		J. J. DEAN		J. J. DEAN		J. J. DEAN		J. J. DEAN	
DATE OF DEATH		HOUR OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
JANUARY 22, 1940		10:30 AM		10:30 AM		98.6		60	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	
J. J. DEAN		J. J. DEAN		J. J. DEAN		J. J. DEAN		J. J. DEAN	

RECEIVED
JAN 23 1940
BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2702

CERTIFICATE OF DEATH

Reg. Dist. No.

02689

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b 7 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1511 Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DR. FRED W. PARSONS		4. DATE OF DEATH February 13 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1923
9. AGE (In years lost birthday) 36 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY self-employed	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur W. Parsons		14. MOTHER'S MAIDEN NAME Hurley Parsons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW #2		16. SOCIAL SECURITY NO. 233-34-0542	
17. INFORMANT Mrs Evelyn Parsons, Pocomoke City, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Artery Disease DUE TO (c) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
INTERVAL BETWEEN ONSET AND DEATH Few Minutes		8 months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1959 to Feb. 13, 1960 that I last saw the deceased alive on Feb. 11, 1960 and that death occurred at 602P M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Trader M.D.		DATE SIGNED Feb. 15, 1960	
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D., 302 Market Street, Pocomoke City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-60	
22c. NAME OF CEMETERY First Baptist		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson		24a. REC'D BY REGISTRAR FEB 23 1960	
ADDRESS Pocomoke City, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF BIRTH		PLACE OF BIRTH		MARRIAGE	
JANUARY 1, 1900		BALTIMORE, MARYLAND		MAY 1, 1920	
AGE		SEX		RACE	
20 YEARS		MALE		WHITE	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
HIGH SCHOOL		LABORER		HEART DISEASE	
MOTHER'S NAME		FATHER'S NAME		DATE OF DEATH	
JANE SMITH		JOHN SMITH		JANUARY 1, 1920	
PLACE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
BALTIMORE, MARYLAND		NATURAL		12345	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
JOHN SMITH		JANE SMITH		JOHN SMITH	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 1, 1920		JANUARY 1, 1920		JANUARY 1, 1920	

CERTIFICATE OF DEATH

02690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 2		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) Albert First Purnell Middle Lost		4. DATE OF DEATH 2 Month 19 Day 1960 Year	
5. SEX LO	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 10, 1954
9. AGE (In years last birthday) 105 yrs.		IF UNDER 1 YEAR — Months — Days — Hours — Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME L. Howard Purnell		14. MOTHER'S MAIDEN NAME Mahalia - Purnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Mrs. Roxie Bailey, Ocean City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X DUE TO C Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-23 , 19 59 , to 2/19 , 19 60 , that I last saw the deceased alive on 2/19 , 19 60 , and that death occurred at 11:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory U. Sully, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED 2-22-60	
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr. M.D.		Berlin Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-23-60	22c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEM-	22d. LOCATION (City, town, or county) (State) Berlin Md.
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Sully, Salisbury, Md		ADDRESS Salisbury, Md	
24a. REC'D BY REGISTRAR FEB 29 60		24b. REGISTRAR'S SIGNATURE Charles S. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1880		1925		HOME		BALTIMORE		BALTIMORE		MD	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		OCCUPATION		CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
JAMES H. HARRIS		JANE H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		LABORER		HEART DISEASE		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO TREATMENT	
BORN		DIED		BURIED		INTERVIEWED		BY		DATE		SIGNATURE		OFFICIAL		TITLE		REMARKS	
1880		1925		1925		1925		J. H. HARRIS		1925		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

CERTIFICATE OF DEATH

Reg. Dist. No.

02691

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 213 Maple Street		d. STREET ADDRESS 213 Maple Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle D. Last SCHOOLFIELD		4. DATE OF DEATH Month February Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1895
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Canning Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Schoolfield		14. MOTHER'S MAIDEN NAME Fannie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW #1 217-09-1721	
17. INFORMANT Mrs Gertrude Schoolfield, Maryland		Address Pocomoke City,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized atherosclerosis DUE TO (c) Ess Hypertension			INTERVAL BETWEEN ONSET AND DEATH 2 hrs 8-9 mths 8-12 mths
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-1- , 19 59 , to 2-24- , 19 60 , that I last saw the deceased alive on 2-24-60 , 19 60 , and that death occurred at 7:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Cecil A. Duverney, M.D.		ADDRESS (Street, city or town, state) 801 - 4th St, Pocomoke	
PHYSICIAN'S NAME (Type) CECIL A DUVERNEY, MD.		DATE SIGNED 2/27/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-28-60	22c. NAME OF CEMETERY OR CREMATORY Halls Hill Cemetery	22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Henry Watson		ADDRESS Pocomoke City, Md.	24a. REC'D BY REGISTRAR DATE FEB 29 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02692

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At home				e. STREET ADDRESS Rural			
3. NAME OF DECEASED (Type or print) First DANIEL Middle TAYLOR Last Taylor				4. DATE OF DEATH Month Feb. Day 12 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1873	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Henry Taylor				14. MOTHER'S MAIDEN NAME Mariah Niblett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) xx		16. SOCIAL SECURITY NO. 220-16-9917		17. INFORMANT Address Beulah Lewis Whaleyville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sunshot wound resulting in complete 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) shattering of skull & evulsion of brain tissue DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH seconds
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suicide					
20c. TIME OF INJURY Month, Day, Year 10⁵⁰ o. m. 2/12/1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Whaleyville Worcester Md	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Norman C. Rabl M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/14/60	22c. NAME OF CEMETERY OR CREMATORY Bale		22d. LOCATION (City, town, or county) (State) Whaleyville, Md		
23. FUNERAL DIRECTOR'S SIGNATURE Robert Whaley				24a. REC'D BY REGISTRAR DATE FEB 16 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Fume	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2698

CERTIFICATE OF DEATH

Reg. Dist. No.

02693

1. PLACE OF DEATH o. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	c. LENGTH OF STAY IN 1b <u>69 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>TAYLORVILLE (RURAL)</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD BURTON TRUITT</u>		4. DATE OF DEATH Month Day Year <u>FEB 8 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1890</u>
9. AGE (In years lost birthday) <u>69 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BROILER</u>	11. BIRTHPLACE (State or foreign country) <u>BERLIN MD (PFD)</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ZADOCK TRUITT</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE JARVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-34-7570</u>	
17. INFORMANT Address <u>MRS. BURT TRUITT, BERLIN MD PFD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>4-6 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While o. m. p. m. <u>19</u> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 8, 1960</u> to <u>Feb 8, 1960</u> that I last saw the deceased alive on <u>Feb 8, 1960</u> and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hermand Kobler</u> M.D.		DATE SIGNED <u>2/10/60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/10/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2699

CERTIFICATE OF DEATH

Reg. Dist. No.

02694

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES PATTON VENABLE</u>				4. DATE OF DEATH Month Day Year <u>FEB. 23 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22, 1874</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRY CLEANER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FIRM</u>		11. BIRTHPLACE (State or foreign country) <u>JONESBORO, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DRURY W. VENABLE</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH ANDERSON PATTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NO</u>		16. INFORMANT Address <u>MR. W. M. VENABLE BERLIN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocarditis</u> <u>431X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Neuropathy</u> DUE TO <u>Senility</u> (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>60</u> to <u>2-23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>60</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford E. Schott</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin Md</u>			
PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT</u>				DATE SIGNED <u>BERLIN MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Barboge Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

2707

CERTIFICATE OF DEATH

Reg. Dist. No.

02695

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Pocomoke		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EUNICE Middle FRANCES Last WILLIAMS		4. DATE OF DEATH Month FEB. Day 3rd Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1923
9. AGE (In years last birthday) 36		10. UNDER 1 YEAR Months 5 Days 18	11. UNDER 24 HRS. Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Waitress	
11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elmer F. McGrath		14. MOTHER'S MAIDEN NAME Mildred Amanda Townsend	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS Mr. Elmer Lee Williams (Husband) 402 Market St. Pocomoke, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, Uterus DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Mo. 12 Mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 11, 1959 to Feb. 3, 1960 that I last saw the deceased alive on Feb. 3, 1960 and that death occurred at 4:55 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Charles W. Trader M.D. DATE SIGNED Feb. 5 / 1960 ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Dr. Charles W. Trader 302 Market St Pocomoke, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 7 / 60	22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Worcester Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR FEB 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1955

270

CHARGE OF DEATH

STATE OF CALIFORNIA
COUNTY OF LOS ANGELES
I, the undersigned, a duly qualified and authorized officer of the State of California, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the State of California.
WITNESSED my hand and the seal of the State of California at the City of Los Angeles, this 1st day of January, 1955.
JOHN W. WATSON, Secretary of State
By _____, Deputy Secretary of State

Notary Public for the State of California
My Commission Expires _____

2704

CERTIFICATE OF DEATH

Reg. Dist. No.

02696

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>				c. LENGTH OF STAY IN 1b <u>42 Pocomoke md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>723 - 6th ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ALINE</u> Middle <u>WINSLOW</u> Last <u>WINSLOW</u>				4. DATE OF DEATH <u>Feb. 1st</u> Month <u>1st</u> Day <u>1st</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1890</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Mills</u>				14. MOTHER'S MAIDEN NAME <u>Annanda Harmon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Madore Long Pocomoke md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Essential Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>4 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dehydration & Electrolyte Imbalance</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6-25-</u> , 19 <u>58</u> , to <u>2-1-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-31-</u> , 19 <u>60</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Beecil A. Duveney</u> M.D.				ADDRESS (Street, city or town, state) <u>801-4th Pocomoke city, md</u>			
PHYSICIAN'S NAME (Type) <u>Beecil A. Duveney</u>				DATE SIGNED <u>2/5/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cool Spring</u>		22d. LOCATION (City, town, or county) (State) <u>Griddle Tree md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - new church, Va.</u>				ADDRESS <u>new church, Va.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 9 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death		9. Signature of Physician		10. Signature of Registrar	
John Doe		Male		White		1/1/1900		New York City		123 Main St		Heart Disease		Natural		[Signature]		[Signature]	
11. Date of Death		12. Time of Death		13. Place of Death		14. Duration of Illness		15. Name of Hospital		16. Name of Physician		17. Name of Nurse		18. Name of Undertaker		19. Name of Burial Place		20. Name of Cemetery	
1/15/1950		10:00 AM		Home		10 Days		St. Mary's		Dr. Smith		Mrs. Jones		Doe & Sons		St. Mary's		Catholic	
21. Name of Informant		22. Relationship		23. Address		24. Telephone		25. Signature		26. Title		27. Date		28. Time		29. Place		30. Signature	
John Doe		Son		123 Main St		123-4567		[Signature]		Registrar		1/15/1950		10:00 AM		Home		[Signature]	

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